MD BIOMETRIC FORM - STEP 2

MEMBER NAME:			EMPLOYER:			
ADDRESS:			PHONE NUMBER:			
DATE OF BIRTH:			EMAIL ADDRESS:			
IS THIS VIST: INITIAL YEARLY EXAM or FOLLOW UP EXAM						
Blood Work Fasting? Yes / No Gender:MaleFem				Female	Currently Pregnant:YesNo	
Health Measure:	Date	Results:			Exceptions:	
Current Smoker		YESNO				
Smoking Cessation Counseling		Completed Declined				
BMI		Height = Inches				
Waist Circumference (optional)		Weight=Pounds Inches			If pregnant use pre-pregnancy information	
Blood Pressure		mmHg			Taking blood pressure medication	
Fasting Total Cholesterol		mg/dl				
HDL:		mg/dl				
LDL:		mg/dl				
Triglycerides:		mg/dl Ratio:				
Glucose		Fasting Blood Sugar:mg/dl			Diagnosed Diabetic	
HgA1C (optional)		%				
HEALTH SCREENINGS						
ProstateBreast Cancer	_YesNoDe _YesNoDe				YesNoDeclined /accineYesNoDeclined	
	_YesNoDo					
	_YesNoD				YesNoDeclined	
o Skin Cancer _	_YesNoD	eclined	o HP	V Vaccine	YesNoDeclined	
Health Practitioner Signature or Office Stamp: Date:						
Health Practitioners Phone Number:						
All information will be kept confidential within the Wellness Program and specific results of an individual will not be shared. Information will be included in the individuals Health Action Report provided at the completion of the Personal Health Profile. The submission of this completed form will be noted and that information used to towards the administration of incentive reward.						
Permission to Release this completed form to the Wellness Office at Empire State Highway Contractors Assn, Inc. Please fax it to the attention of the Wellness Coordinator at 315-895-5307						
Members Signature: Date:						

- 1. Make your appointment to complete your Annual Physical Exam (include blood work)
 - a. Give this form to your Doctor's office for completion
 - b. Once complete, mail to: Wellness Coordinators Office
 Empire State Highway Contractors Office
 2481 Higby Road, Frankfort, NY 13340

- or -

fax: 315-895-5307

e-mail: pflaherty@eshca.org

- 2. This exam is covered by your insurance once within the calendar year (\$0 copay). Be sure to take your medication list so you can re-evaluate your medications and dosages with your doctor.
- **3.** If you have already completed your exam for the current year, drop this form off to your doctor's office for completion. Either make arrangements to pick it up or have them send it in on your behalf.

Follow the 3 Steps to Receive the \$200 Incentive:

- 1) Complete the General Health Assessment (<u>www.eshca.org</u> or call/email me)
- 2) Submit MD Biometric Form
- 3) Submit MVP Explanation of Benefits (receipt from MVP)

\$200

Questions or comments contact:

Patrick Flaherty MSE, CSCS ESHCA Wellness Coordinator

Phone: 315-895-5303 Fax: 315-895-5307 pflaherty@eshca.org

Website: www.eshca.org